



GEORGIA COMPOSITE BOARD OF PROFESSIONAL COUNSELORS,
SOCIAL WORKERS AND MARRIAGE AND FAMILY THERAPISTS
237 Coliseum Drive, Macon, Georgia 31217-3858
(478) 207-2440 (Telephone) www.sos.state.ga.us/plb/counselors

PROFESSIONAL COUNSELOR
PRACTICUM/INTERNSHIP SUPERVISION VERIFICATION — FORM A

INSTRUCTIONS: Please type or print clearly. **NO FAXED FORMS ACCEPTED.**

APPLICANTS:

- Complete Part I and submit to your Practicum/Internship Supervisor. See Board Rule Chapter 135-5-.02(a)5.
- If you have more than one practicum or internship, submit a form for each. You may photocopy this form.

PRACTICUM/INTERNSHIP SUPERVISOR:

Complete Part II, noting requirements. Please enclose this form in a sealed envelope. Sign your name over the flap and then either mail it to the applicant or send it directly to the Board office. Fax copies are not acceptable.

The Practicum/Internship must:

- Be part of the master's degree program,
- Be in Professional Counseling or in applied psychology before January 1, 2004
- Include a minimum of 300 hours in the practice of Professional Counseling under supervision.

The Practicum/Internship Supervisor must:

- **Be the Instructor of Record at the college or university, or the Site Supervisor; and,**
- Either be licensed — as a Professional Counselor, Clinical Social Worker, Marriage and Family Therapist, Psychologist, Psychiatrist — or be a Certified Rehabilitation Counselor. See Board Rule Chapter 135-5-1(a) 5 for further details.

PART I - APPLICANT

NAME:

SOCIAL SECURITY NUMBER:

PART II — SUPERVISOR

NAME:

ADDRESS: _____
Street City State Zip Code

TELEPHONE: ()

FAX: ()

TYPE OF LICENSE: ☐ Professional Counselor ☐ Clinical Social Worker ☐ Marriage and Family Therapist
☐ Psychologist ☐ Psychiatrist ☐ Certified Rehabilitation Counselor

LICENSE #:

STATE:

ORIGINAL DATE ISSUED:

EXP. DATE:

Highest Level of Education Completed Master's EdD PhD Other

CERTIFICATION OF SUPERVISION:

I hereby certify that I supervised the Internship/Practicum of the above-named applicant who practiced Professional Counseling work at:

NAME OF PRACTICUM/INTERNSHIP SITE: _____

FROM: _____ TO _____ FOR A TOTAL OF _____ HOURS.
MONTH/YEAR MONTH/YEAR # HOURS

DESCRIBE THE PRACTICE SUPERVISED: _____

VERIFICATION: I attest that I provided the supervision described above and that this is a true and accurate representation of this supervision.

Date

Signature of Supervisor/Instructor of Record

Sworn to and subscribed before me this

_____ day of _____, _____.

Notary Public

My Commission Expires: _____

NOTARY SEAL